

FILED APR 11 1950

STANDARD CERTIFICATE OF DEATH

5466 State File No. 8388

320

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>GEORGIA</u> b. COUNTY <u>Floyd</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield Rural</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rome,</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Medical Center for Federal Prisoners</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) <u>Fred</u>		a. (First)		b. (Middle) <u>--</u>		c. (Last) <u>Sheppard</u>	
4. DATE OF DEATH		(Month) <u>4</u>		(Day) <u>2</u>		(Year) <u>50</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 16, 1907</u>	
9. AGE (In years last birthday) <u>42</u>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 YEAR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Thomas Sheppard</u>		13b. MOTHER'S MAIDEN NAME <u>Lula Sheppard</u>		14. NAME OF HUSBAND OR WIFE <u>Mattie Sheppard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>256-44-2202</u>		17. INFORMANT'S SIGNATURE OR NAME <u>FILE M.C.F.P.</u> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage from vessels of brain</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis, general</u> DUE TO (c) <u>Uremia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Infected wound of the scalp and</u>				INTERVAL BETWEEN ONSET AND DEATH <u>22 hours</u> <u>5 yrs over</u> <u>10 days</u> <u>2 3/4</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>malnutrition</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>March 18, 1950</u> , to <u>April 2, 1950</u> , that I last saw the deceased alive on <u>April 2, 1950</u> , and that death occurred at <u>2:50P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>J.E. Robinson</u> (Degree or title) _____		23b. ADDRESS <u>Medical Center for Federal Prisoners, Springfield, Mo.</u>		23c. DATE SIGNED <u>4-3-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Apr. 3, 1950</u>		24c. NAME OF CEMETERY, OR CREMATORY <u>do not know</u>		24d. LOCATION (City, town, or county) <u>Atlanta, Georgia</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>4-6-50</u>		REGISTRAR'S SIGNATURE <u>W.S. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred C. Thorne</u> ADDRESS <u>Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ralph A. Threine

Licensed Embalmer No. 3681

P. O. Address Springfield Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.